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# Caring HEADLINES

# Stephanie M. Macaluso, RN, Excellence in Clinical Practice Awards

Inside:

Special Issue

Macaluso Award Ceremony .... 1

Corrina Lee, RN .................... 2
Jane Loureiro, PT ........... 4
Paula Nelson, RN ...... 6
Angela Sorge, RN .. 8

Fielding the Issues . 18
- Expanding Medical Interpreter Services

Educational Offerings .. 19

History and Background of the Macaluso Awards .......... 20

There's a reason the Stephanie M. Macaluso, RN, Excellence in Clinical Practice Awards have attained the level of prestige they've come to enjoy. It's because year after year, clinicians push the bar higher, establishing new standards of excellence in patient care. And this year was no exception. Recipients of the 2006 Stephanie Macaluso, RN, Excellence in Clinical Practice Awards are: Corrina Lee, RN; Jane Loureiro, PT; Paula Nelson, RN; and Angela Sorge, RN.

In a ceremony held January 11,

*continued on page 15*

Senior vice president for Patient Care, Jeanette Ives Erickson, RN (left), with 2007 Macaluso award recipients (l-r): Jane Loureiro, PT; Angela Sorge, RN; Corrina Lee, RN; and Paula Nelson, RN

MGH Patient Care Services
Working together to shape the future

# Corrina Lee



*A graduate of the William F. Connell School of Nursing at Boston College, Corrina Lee has practiced on the Bigelow 7 Gynecology-Oncology Unit for more than ten years. Her practice is guided by clinical expertise, research, and a kind and compassionate approach. Lee teaches patients about cancer, treatment, ways to manage side-effects, and how to adjust to their changing self-image. She educates and supports families as they learn to live with their loved one's cancer diagnosis. Lee teaches and mentors others. In a complex clinical setting, Lee guides less experienced nurses and physicians in administering state-of-the-art infusions and supports patients and families at the end of life.*

Corrina Lee, RN
staff nurse, Gynecology-Oncology Unit

## Clinical Narrative

Working on the Bigelow 7 Gynecology-Oncology Unit, clinicians are able to form lasting relationships with patients and their families. That's because patients return to Bigelow 7 as they continue to receive treatment for their cancer. I look forward to entering every patient's room as each experience is always different.

I enjoy getting to know patients as people, listening to their stories and learning about their lives. When I look back on my narratives and correspondences with patients and families over the years, they're about spiritual interactions, end-of-life issues, meaningful relationships, and cultural care. It feels strange to write about an encounter with a patient whom I only met once, but it's just another example of how care isn't measured by hours or days, but by the quality of the experience. It's hard sometimes to put the natural art of caring into words, but I want this narrative to reflect a typical day in caring for women with cancer.

Mrs. G was a lovely 58-year-old woman who was newly diagnosed with Stage III, high-grade, serous carcinoma of the ovary. She and her husband had come to MGH from another state for treatment. She was a seasoned real-estate broker who had a wonderful network of friends, evident from all the correspondences adorning her room.

Mrs. G would need surgery in the future, but had been admitted with symptoms of nausea and leg-swelling. An ultrasound of her lower extremities had ruled out DVT (deep vein thrombosis). We were hoping chemotherapy would help alleviate her nausea as well as fight the disease process.

I knew that the emotional impact of the word 'chemotherapy' would be overwhelming to Mrs. G and her husband. It's difficult enough to be in the hospital, let alone one so far from home. She was going through a lot in an unfamiliar setting. And on top of everything else, she was feeling fragile, sick, scared, and she was dealing with the emotional impact of the word 'cancer.'

When I walked into her room, I sensed a positive energy as I saw Mrs. G's pleasant smile so early in the morning and with so much on her mind. I leaned down and gently placed my hand on her shoulder as she lay in bed. I introduced myself and told her I was sorry for what she was going through. She appreciated the kind words. When I asked if I could pull a chair up, she smiled and eagerly agreed.

I asked if the doctors had told her she'd be getting chemotherapy today and what, if anything, she knew about it. We discussed her plan for the day. Even though she was a strong woman and trying to be positive, I sensed an uneasy feeling, which was understandable. I asked if she was scared. We talked about fear of the unknown, chemotherapy, and I gave her an opportunity to ask any questions she had. I asked if anyone would be coming in today, and whether she wanted me to review this teaching with them as well.

Mrs. G's husband came in about an hour later, and throughout the day we talked in more detail about the risks and side-effects of chemotherapy. I didn't want to overwhelm them with too much information, even though they seemed eager to learn and had many questions, including how their environment would be affected. Experience has taught me to introduce information a little at a time in appropriate increments. We talked about a number of possibilities, future planning, what to expect, how others might react, how people respond differently to chemotherapy and not to assume she would experience the same side-effects as others.

I continued to keep Mrs. G informed every step of the way and prepared her for what to expect next. I arranged to have her transferred to a private room so she could get some sleep after her treatment—they had a long car ride in the morning back to their home state.

With Taxol, there's less than an 8% chance that patients will have an adverse reaction (anaphylaxis), but I set up the room for a worst-case scenario just to be prepared. Past experience told me to make sure there was a physician on the unit for any needed orders, and I explained the potential scenario to the new resident.

Unfortunately for Mrs. G, I needed all interventions. After not even one cc of the drug (which is usually the case), she began to have a reaction. Her reaction was dramatically different from others I had seen. Immediately after the chemo started infusing, she became nauseous and sat up to get the basin. The way she said she was nauseous was different from how

*continued on page 10*

Bigelow 7 staff nurse, Corrina Lee, RN, with patient, Annette Misiaszek

# Jane Loureiro



*Jane Loureiro received her bachelor of Science degree in Physical Therapy from Russell Sage College and her master's degree in Science from the MGH Institute of Health Professions. A physical therapist for almost 30 years, Loureiro has worked at MGH for the past seven. A recognized expert in spinal dysfunction, she is sought out by all members of the team to consult or treat the most challenging cases. Through her expert knowledge of the spine and related structures, Loureiro is able to diagnose and treat patients whose problems had confounded other practitioners. Loureiro has developed teaching models to enhance the clinical skills and reasoning of less experienced staff and has sought formal and informal settings to teach and mentor. She is committed to excellence in her own practice and in developing excellence in others.*

Jane Loureiro, PT
physical therapy clinical specialist

## Clinical Narrative

The patient I'm going to describe was referred for physical therapy services to MGH West in Waltham with a diagnosis of spinal stenosis. Mrs. S is an alert and oriented 94-year-old woman, widowed several years ago, living alone in her own home. She has two grown daughters in the area and several grandchildren.

I picked up Mrs. S's chart at the front desk, scanned it quickly, then called her name. She jumped up, bent over, picked up her pocketbook and gym bag, and extended her hand to greet me. She did this easily with no obvious mobility or balance problems, or pain. She was accompanied by her daughter, a former patient of mine. Her goals were clear from the outset. She asked if I was going to be the one who would make her problem go away. Then I observed her as we walked the 15 feet to the treatment room. She had no obvious gait or balance problems, but her postural problems were obvious. I asked Mrs. S to have a seat in the treatment room and I continued to observe her movements and posture.

We spent the next few minutes talking about her problem and reviewing her medical history. Mrs. S reported that her pain began approximately five weeks ago and was located in the buttocks and posterior aspect of both legs, extending from the thighs into the calves. It came on within a few minutes of walking. She described the pain as an intense aching sensation that was relieved almost immediately by sitting down. She could no longer walk the length of her driveway to pick up the mail (about 25 feet), do her own shopping unless she had a shopping cart, or walk to play her usual nine holes of golf. Mrs. S reported she normally played twice a week with her friends all year long, here and in Florida, alternately walking and using a golf cart.

I asked about other activities and sleeping. Mrs. S reported no significant problems with her back or legs other than occasional intermittent backaches over the years. She thought backaches were pretty normal for someone her age, and they didn't keep her from doing her regular activities. Nothing else really bothered her. She was able to do grooming, bathing, meal preparations and light homemaking without trouble. She employed a housekeeper for heavier tasks and someone else for yard work. She reported no problems sleeping. Mrs. S shared that she was active throughout the day and always read *The Boston Globe* cover to cover, including the sports section.

Since getting the results of her MRI, Mrs. S reported she was afraid she'd aggravate her back, so had stopped gardening and was no longer going to the gym. She normally worked out with a personal trainer a couple of times a week, mostly for upper-body strengthening to help with osteoporosis. Mrs. S said she was concerned about the results of her MRI. She felt limited in her ability to take care of herself and her home. She said she hoped this wasn't the end for her. She said she'd seen the decline of many of her friends and family members; once they could no longer do what they liked doing, they usually didn't live much longer. Mrs. S didn't seem depressed but was obviously very concerned. I'd never had a patient explain the effect of her problem quite that way. I appreciated her candor and understood from the beginning her goals for physical therapy.

We continued to review Mrs. S's medical history and medications. Mrs. S gave me a copy of her MRI report, performed at another location. Much of Mrs. S's medical information was unavailable through CAS and LMR as her care and hospitalizations had taken place elsewhere, (not uncommon for the outpatient physical therapy setting).

Mrs. S was a good historian and I was thorough in reviewing her medical history. The MRI revealed multi-level degenerative changes of the L/S spine with disc-degeneration and narrowing, ligament flavum infolding causing central canal stenosis particularly at L3-4 and L5-S1, with facet joint arthropathy, especially at L4-5 and lateral foraminal stenosis. Mrs. S wore glasses and her hearing was fine. She had a pacemaker for atrial fibrillation, high blood pressure and cholesterol, and a history of reflux and diverticulitis for which she had recently been hospitalized. Mrs. S had renal insufficiency, repeated urinary tract infections, nocturia with urinary incontinence, and osteoporosis for which she had been taking Fosamax until this recent hospitalization for GI problems. She was scheduled for

*continued on page 12*

Physical therapy clinical specialist, Jane Loureiro, PT, with patient, Greta Grantcharova

# Paula Nelson



*A graduate of Bristol Community College, Paula Nelson received her bachelor of Science degree in Nursing from the University of Rhode Island. Nelson has practiced Obstetrical Nursing for more than 20 years and is a recognized expert in the care of women during labor, delivery, and postpartum. Approximately 20% of women who deliver at MGH are high risk, requiring intense monitoring, care, and support. Nelson is viewed as an expert by all members of the team. She never allows technology to interfere with the care of her patients. She is committed to developing and maintaining systems that support quality and safety; she provides leadership for unit-based initiatives; and she participates on Partners-level committees and activities. Nelson's accessibility, non-judgmental manner, and willingness to teach make her an invaluable member of the obstetrical nursing team.*

Paula Nelson, RN
staff nurse, Labor & Delivery Unit

## Clinical Narrative

When contemplating what to write about in this narrative, I initially thought of describing a critical event such as a cord prolapse, or an emergency Cesarean section, or another of the many emergent situations we deal with on the Labor & Delivery Unit. I thought about what it is that makes my job as a labor nurse special and rewarding. I decided to share my experience caring for a laboring patient who chose to give birth without an epidural.

I was assigned to care for Mrs. C, a Spanish-speaking patient who was being admitted already in labor. I noticed she was alone, and when the interpreter arrived, I performed her assessment. I asked about her home situation and whether anyone would be with her in the labor room. She told me her husband was at work, and her only other family member was home taking care of her two other children. This is not an uncommon situation for many patients, and although she didn't appear to be upset, I was sad for her.

Mrs. C didn't want an epidural during labor, and this being her third child, she progressed nicely. In my many years of experience, I've noticed that most Spanish women are very stoic when they go into labor, and it's sometimes difficult to know how or when they need help coping. Throughout Mrs. C's labor, I didn't leave her side. I rubbed her back, put cool compresses on her forehead, and offered encouragement in my limited Spanish. Often, I just sat with her and held her hand. She didn't ask for anything, and at times, I wasn't sure if she even wanted me there, but I stayed just the same.

After a couple of hours, Mrs. C delivered a beautiful baby boy with the midwife and me at her side. The midwife spoke Spanish and was able to communicate with Mrs. C during the delivery. I congratulated Mrs. C and gave her a big hug after her baby was born. I told her I was sad that her family had missed the beautiful delivery.

She didn't hesitate and replied, "You were with me, you were my family."

I was touched by her comment and so glad I was able to make her birth experience a positive one. Even with the language barrier, we had been able to communicate through the universal power of touch and compassion.

The demands of being a registered nurse have changed immensely since I became a nurse in 1981. When I started as a labor nurse, I worked in a facility where no epidurals were offered. I would stay with patients and offer them massages, position changes, and assist them with relaxation and breathing to help them cope.

The majority of patients now have epidurals to ease the pain of labor. I see our role as nurse becoming more technical in nature.

Some days I feel as if the new generation of labor nurses is so used to caring for patients with epidurals and technical skills that basic, bedside support is becoming a lost art. It's difficult to care for a patient in labor and not be able to fix the pain she's experiencing. A certain comfort level is required to say, It's okay to have pain during labor. Not everyone wants or needs pain medication.

Functioning in the role of staff nurse and resource nurse, I'm frequently in a position to mentor other nurses. I continue to advocate for patients by teaching and supporting staff with the goal of enhancing the skills needed to comfortably care for the unique patient population on the Labor & Delivery Unit.

Caring for Mrs. C touched me; I will always remember her and her birth experience. Moments like that reinforce why I became a nurse.

**Comments by Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse**

Paula talked about wanting to write a narrative that would describe why she feels her work is so rewarding. I think she made an excellent choice in writing about Mrs. C. Her presence, even when she was unsure if Mrs. C wanted her to be there, was invaluable. Her presence was a comfort in the absence of her own family. Her presence during this most intimate and life-altering moment speaks directly to the 'art' of nursing.

We are fortunate to have someone with Paula's years of experience and clinical 'memory,' to share these stories with us. Thank-you, Paula.

Obstetrical staff nurse, Paula Nelson, RN,
with patient, Amy Coughlin

# Angela Sorge



*A graduate of St. Joseph's University with a bachelor of Science degree in Biology, Angela Sorge received her bachelor of Science degree in Nursing from the University of Delaware. She has worked on the Ellison 11 Cardiac Access Unit for six years. Many patients on Ellison 11 are admitted following cardiac interventions and often stay in the hospital for only a few days. These patients require close monitoring and education about how to live with cardiac disease. Sorge combines expert understanding of cardiac disease with a commitment to patient-education. Whether it's caring for a patient newly diagnosed with cardiac disease, preparing a patient for a procedure, or removing a vascular sheath, Sorge focuses on educating and empowering her patients.*

Angela Sorge, RN
staff nurse, Ellison 11 Cardiac Access Unit

## Clinical Narrative

Throughout my childhood, Yom Kippur meant nothing more to me than a day off from school. Growing up in a strict Catholic family, I didn't know very much about Yom Kippur. I did know that school was canceled and that most of my Jewish classmates would be in synagogue with their families. Like every other holiday, it would soon be forgotten until it rolled around again next year.

On I went to attend a Catholic university. I became more involved with, and knowledgeable about, my own religion and beliefs, but I became increasingly separated from other religious traditions. Do I blame myself for not fully connecting with other religious beliefs? Not totally. But looking back, I think I could have been more aware of other religious practices. I had only a limited understanding of Yom Kippur. It was a holiday that was deeply important to the Jewish community.

I moved to Boston several years after finishing college. Along with my move to Boston, came my new interest in running marathons. Believe it or not, it was while running that my thoughts of the Jewish religion resurfaced. On Saturdays, I'd run the marathon course backward, which meant running along Commonwealth Avenue. While running, I'd see Jewish families coming and going and once again realized it was the Sabbath, their holy day.

Every Saturday thereafter, as my long runs gave me time to think, I'd wonder what their Saturdays were like; I marveled at their dedication to their religion. But I observed their practices from afar, so I never really understood or appreciated what the Jewish faith was all about. That is... until I met Mr. M.

Mr. M was a 'typical' patient admitted to the Cardiac unit. He had a history of insulin-dependent diabetes, hypertension, high cholesterol, a family history of coronary artery disease, and ulcerative colitis. Mr. M presented to the Emergency Department after experiencing chest pain. He was ruled out for myocardial infarction, but proceeded to have a cardiac catheterization. His coronary catheterizations revealed that Mr. M had vessel disease, (including 70% left main, 95% proximal LAD (left anterior descending) and severe RCA (right coronary artery) disease. He was admitted to our unit in stable condition to await coronary-artery bypass surgery. The good news was Mr. M would be able to have his surgery soon because there was an opening in the OR schedule. But this was also bad news, because Mr. M was an orthodox rabbi, and Yom Kippur was only a few days away.

According to Rabbi M, Yom Kippur was the 'high holiday,' the most solemn holiday, and he didn't want to be recovering from cardiac surgery during this time, even if it meant putting his health at risk. For Rabbi M, Yom Kippur involved his whole body, mind, and spirit. Despite our misguided attempts, Rabbi M refused to undergo cardiac surgery as planned and said he intended to wait until after Yom Kippur. In fact, his wish was to *leave* the hospital for the holiday. It was difficult explaining to Rabbi M why it was important for him to *stay* in the hospital. He repeatedly said he felt fine and wasn't experiencing any chest discomfort. It's hard to impress upon patients the seriousness of coronary artery disease when they don't 'feel sick.' They say, "If I'm so sick, why do I feel okay?"

My intuition told me the rabbi was thinking these very thoughts. I knew I had to sit with him and explain the nature of coronary artery disease. I spent time with him, talking about the blockages in his arteries, and more significantly, the location of the blockages. I explained how the left main artery (which was 70% blocked) supplies the blood to a significant area of the heart and without it, the heart wouldn't be able to get the oxygen it needs. A lack of oxygen could damage the heart or cause a heart attack. I clarified that, although he might feel fine, the potential for a dangerous situation was very real. I stressed that we would be watching him closely and it would be safer for him to await surgery in the hospital.

I discussed the need for him to receive intravenous heparin to help thin his blood while he was waiting for surgery. We talked about how important it was for him to let us know if or when he felt discomfort in his chest. I told him about the many interventions he might experience prior to surgery, such as electrocardiograms (EKGs), blood draws, blood-pressure checks, and changes in his medications. After we talked, Rabbi M appeared to have a better sense of his clinical situation. He agreed to stay

*continued on page 11*

Ellison 11 staff nurse, Angela Sorge, RN,
with patient, John Wilkins

## Narrative (Corrina Lee)

*continued from page 2*

she had said it before, (we had been trying to control her nausea throughout the day). Nausea is not a typical reaction to Taxol, but I stopped the chemo immediately when she went for the emesis basin. Even the look on her face didn't feel right to me—as if she were confused about what was happening inside her. As I reached for the oxygen, all the typical symptoms occurred, shortness of breath, a red, flush feeling in the face. As I tried to make her comfortable my heart ached for her. I could only imagine her feeling of panic at turning bright red, being unable to catch her breath, her lips, tongue, and hands swelling. I looked her in the eyes as I re-placed the oxygen and said, "I'm right here. Hang in there."

I called her doctor and a code. As a team, we worked together to stabilize Mrs. G. Her husband stayed right in the bed with her, holding her hand. He put aside his own fears and was really the best medicine for her. I could tell from his demeanor, mannerisms, and focus, it was okay for him to be in the room. We worked around him.

At one point he looked up and said, "What if we can't give her this kind of chemo? What will happen?"

I told him that as soon as we got her comfortable, we would explain her other options. He nodded and felt reassured. I wanted them to know they had options. Information is control, and I was sure they were feeling out of control with the recent turn of events.

When Mrs. G recovered, we spent a good deal of time discussing her options. Mrs. G wanted to resume the Taxol, feeling she had more medicine on board and might not have the same reaction. I sensed that Mrs. G felt the doctor's offer of Taxotere might not have the same effect on her cancer. Mr. and Mrs. G decided to try the Taxol again, feeling it was her best option.

The doctor said we could resume treatment right then and there. I had no problem resuming her treatment, but her lips and tongue were still quite swollen, despite normal vital signs. She was still having difficulty speaking due to the swelling in her tongue.

Outside the room, I suggested we prepare for a full respiratory arrest with intubation in case the situation worsened when we re-tried the Taxol. The physician agreed it was a valid concern. I asked that a member of the code team be on the unit ready to intubate, but that wasn't possible, so we moved her to the ICU just in case a higher level of care became necessary.

I knew taking her to the ICU was the safest option even though I didn't want to see her leave our unit, and I didn't want to add to their stress. I re-entered their room to explain this to Mrs. G and her husband and asked if they had any questions. They were sad to be transferred from our unit but truly appreciated my putting their safety first. I reassured them that the ICU staff would take good care of Mrs. G.

On my way out of the hospital that night, I stopped by the ICU to make sure they were okay, especially Mr. G who'd had some time to process what had happened.

I found him in the waiting room, and it looked as if he'd been crying. I gave him a big hug and there was just this silence. I sat with him and talked about all the images he was replaying in his mind and what it all meant. I told him I knew it wasn't easy. He told me what he'd experienced from his perspective. I asked what he was going to do; where he would stay that night; I prepared him for the possibility that he might not be able to sleep; but mostly I just listened.

Later, I asked the ICU nurse if the social worker could stop by and visit them. Given the event they'd just experienced, I thought they could use it.

I was off the next day and was able to decompress and enjoy the day. I did call to check on Mrs. G and see how she did with the re-trial. She had another reaction, even with the test dose (only 1/1,000 of the prescribed drug).

Looking back, I had started Mrs. G's initial infusion very slowly because I knew she was a natural person whose body wasn't used to medications. She knew her body well and I always asked how she felt because, like most patients, she was the best judge of her own body. Today, I feel certain that starting her chemo slowly, recognizing her atypical reaction, and stopping it immediately, saved her life.

I know I'm blessed to work with the team on Bigelow 7, but a situation like this is just another example of how well we work together during stressful times.

I'm always interested in learning how my patients are doing after they leave MGH. Mrs. G's oncologist told me she is currently on a different chemo regimen, which seems to be working. She and Mr. G are enjoying their home and are in good spirits. A couple of months after leaving, Mrs. G sent her oncologist an e-mail saying, "I hope when I'm in the hospital next I get to see that wonderful nurse, Corrina Lee, who saved my life. She's wonderful. I had hoped to see her before I left, but in the discharge process, I missed her."

Recently, I received a letter from Mrs. G expressing her gratitude for my care. She called me her hero, "an angel in nurse's clothing." This was amazing, because I thought she was the hero. She was the one who endured, as her oncologist called it, 'the worst allergic reaction to Taxol in the history of MGH.' She said it was nice to be able to look back on that day and joke about it. As a result, Mrs. G made a significant life change. She retired from her real-estate job to enjoy life and do the things she's always wanted to do.

Mrs. G's spirit, smile, and strength will always be with me. Working on Bigelow 7 allows me to form close bonds with patients, which reinforces my commitment to provide the highest quality care I can.

### Comments by Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse

This narrative gives us insight into the hopes and challenges of administering chemotherapy. Corrina's experience, knowledge, and compassion all came into play as she provided exceptional, personalized care to Mrs. G. Corrina took the time to get to know Mrs. G, which informed her decision to start treatment at a lower rate than ordered. When Mrs. G reacted, Corrina reacted quickly to stabilize her. Her continued care of Mrs. G and her husband throughout this trying time is a testament to her clinical skill and nursing instincts.

Thank-you, Corrina.

## Narrative (Angela Sorge)

*continued from page 8*

in the hospital, but was persistent in his decision to wait until after Yom Kippur to undergo open-heart surgery.

I shared my conversation with the rest of the interdisciplinary care team. Many of us wondered why a man needing open-heart surgery would want to wait. Wouldn't God understand? His health, perhaps his life, was at stake. But I realized those were my beliefs, my values, and it wasn't up to me or the team to decide what was acceptable for Rabbi M.

Rabbi M had made it very clear where he stood. He wanted to wait. I knew I had to shift my focus and support his decision. I had to be his advocate.

Rabbi M did not have surgery until the Tuesday after Yom Kippur. In the days leading up to his surgery, we tried to plan for every possible occurrence so Rabbi M could feel comfortable adhering to his religious and cultural beliefs while awaiting surgery. Chaplaincy was consulted to help support Rabbi M and help facilitate any needs he may have. Rabbi M, his family, my nurse manager, and I collectively made a schedule. Our unit conference room was made available so Rabbi M could have some privacy for his prayers throughout the Sabbath and until Yom Kippur. The Friday before the Sabbath, I made sure the care team knew his prayer schedule. We all worked together to get his tests done prior to the Sabbath and Yom Kippur because during those days he wouldn't be able to use the elevator (nor would his family members). We collaborated on a plan for his meals. Although we were able to provide kosher meals, we cancelled his meals from Nutrition & Food Services as his family wanted to bring in their own food.

I discussed the need for intravenous fluid hydration for Rabbi M during his fasting. Rabbi M was on insulin and would be fasting for the holiday. Along with the endocrinologist, we worked out a fasting plan that would control his blood glucose levels. Another issue was the administration of potassium replacements. Because of Rabbi M's cardiac condition, we were vigilant about checking his electrolytes. Rabbi M's potassium level had been low and needed supplementation. Unfortunately, the gel capsules housing the potassium are not kosher. So Rabbi M's family brought in kosher capsules, and we were able to administer the potassium that way.

We worked hard to 'tie up any loose ends' before the holiday weekend. I wanted everything to be ready for him. Days were spent making arrangements. But perhaps equally important, I sat with Rabbi M and listened to what the Sabbath and Yom Kippur meant to him. He shared his religious history, telling me his Jewish community was located in the area. I thought back to my long runs, seeing the Jewish families going to synagogue every week. I felt sure Rabbi M was part of their lives.

Saturday morning, I was Rabbi M's nurse again. As I went about my morning routine, I tried to be sensitive to his cultural practices. I realized just how 'holy' that holy day was to him and his family. Rabbi M didn't even want to open a tissue box; this was his practice on the Sabbath.

Rabbi M's son was in his room that day, which proved to be vitally important. Rabbi M didn't want to use the call bell because it's an electric device. I had concerns about this. I thought, What if he has chest pain, how will he tell me? I checked on him frequently, but it was impossible to stay by his side the entire day. His son, therefore, stayed with him, and Rabbi M was able to tell his son if he needed anything. As it turned out, during the next shift, Rabbi M did experience chest discomfort. An EKG showed no changes, and he was pain-free after two doses of sublingual nitroglycerine. I realized how important it was to be able to include his family in his care. Rabbi M's refusal to use the call bell made me uneasy, but the fact that his family was there made a world of difference. They allowed him to remain true to his beliefs without compromising his health.

Later that day, Rabbi M's son came looking for me (and the nurse I was precepting). He had a concerned look on his face and asked if we were Jewish. We told him we weren't, but wondered why he asked. He said his father felt he'd been treated with so much respect, he thought we might be Jewish. He was worried because if we were, caring for him might be interfering with our own religious beliefs. It was then I realized how deeply committed he was to his religion, and I felt the utmost respect for him. It was rewarding for me to know that Rabbi M felt so comfortable in our care. We had been able to accommodate his faith while keeping him safe as he awaited open-heart surgery.

The weekend passed and Yom Kippur arrived. Rabbi M was dressed in his Kittel. He would stay in the conference room all day praying. Having this designated space worked out well for both Rabbi M and his roommate. He spent the day there with family, only coming out when staff needed to assess his health status and check his vital signs. Yom Kippur was truly a day of prayer for Rabbi M.

I don't have a full understanding of the Jewish Orthodox religion, but I do have a greater sense of their beliefs. And I realize how important it is to respect all patients' cultural practices despite their medical condition or situation.

Rabbi M came through surgery with no complications. I'm pleased we could support him while he received the medical attention he needed. His son came to the unit to thank staff, and just last week we received a card from Rabbi M, thanking us for the care he received. It's one of those times I remember why I love my job.

Now when I run up Commonwealth Avenue and see people observing the Sabbath, I have a better understanding of their worship. And I always think fondly of Rabbi M.

**Comments by Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse**

We can see in every aspect of this narrative that reflection is an important part of Angela's practice. Her willingness to open her mind to unfamiliar practices and allow herself to suspend her own beliefs to meet the needs of her patient starts her on a journey of understanding. She became a resource and an advocate for Rabbi M and his family. She no longer saw barriers, but opportunities to provide high-quality, individualized care.

Through teamwork, compassion, and perseverance, Angela turned what could have been a problematic hospitalization into a rewarding one.

Thank-you, Angela.

## Narrative (Jane Loureiro)

*continued from page 4*

another bone-density test in the fall, but her last scan had been stable. Her medications were written down. They included Metoprolol, Cozaar, Lipitor, Protonix, low-dose Amiodarone and Aranesp.

Even though the MRI showed significant changes, Mrs. S's problem was relatively new. Experience told me that was a good sign. But considering Mrs. S's advanced age, the major changes in her life roles, her diminished participation, and her level of worry, I had some concerns. Knowing more about Mrs. S's current state would help direct my examination and treatment priorities. I had several questions. I asked Mrs. S if she had any numbness or tingling in her lower body, including the perineum, or if she'd experienced any changes in her bowel or bladder function. I asked how steady she felt on her feet when standing and walking in her home, community, or at the golf course. I asked if she'd fallen in the last year. I asked what she knew about her osteoporosis and whether she'd broken any bones. I reworded some of my questions and asked how she was doing her activities of daily living at home and at the gym. Once I knew all this, I could begin to think about how to perform my examination.

I considered several factors about Mrs. S's diagnosis and medical history, relying on clinical knowledge and past experience to guide me. Spinal stenosis can result in spinal-cord compression with sensory and motor changes resulting in weakness and changes in sensations that can severely affect functionality. Stress and urge-incontinence are not uncommon problems, especially for women who've given birth a number of times. And if there has been a change in bowel or bladder function, that could suggest a more significant cord compression.

As people get older, their risk of falling increases. Many factors including environmental risks, sedentary lifestyle, behavioral issues (poor judgment, cognition, or depression), medications, medical history, or changes in postural control could result in falls. Statistics show 1/3 of adults over 65 fall each year, many resulting in significant injury, disability, and sometimes death. With a diagnosis of spinal stenosis, sensory and motor changes could result in lower-extremity weakness and changes in sensation and proprioception with changes in stability, gait, and an increased risk of falling.

Considering Mrs. S's age, history of nocturia, and the fact that golf requires a high level of skill including stability and mobility on uneven ground, any compromise in her sensory or motor function could increase her fall risk.

A diagnosis of osteoporosis versus osteopenia or normal bone density means there is considerable bone loss relative to her age (though at 94, Mrs. S was older than the oldest bone-density age reference). Besides an increase in fracture risk, loss of vertebral body height results in altered alignment and loading of the spine, as do the degenerative changes revealed in Mrs. S's MRI. If the alignment changes become fixed over time and the changes in loading create pressure on tissues not designed for that stress, signs and symptoms will ensue.

Clinically, we know osteoporosis can be a problem across the ages for both men and women. Even before bone loss can be picked up on conventional X-rays, loss of normal height and/or postural changes are indicators of osteoporosis. Whether or not these signs are present can assist in clinical decision-making, and I considered this in Mrs. S's case. Because we don't know exactly the type or intensity of force that could result in a fracture, the presence of osteoporosis has a direct impact on the selection and application of physical therapy techniques, as well as the design of an appropriate posture, body mechanics, and home-exercise program.

I had already observed Mrs. S's flexion-predominant body mechanics as she got up and down from her chair and bent to retrieve her bags. I asked Mrs. S to describe her gym exercises. She demonstrated a rowing type exercise and others that involved outstretched and overhead resistance of the upper extremities. I was concerned. These exercises could create problems by overtraining the flexor muscles in a shortened range and under-training the more important postural extensor muscles in a lengthened range, which could exacerbate her postural problems. Studies have shown that flexion exercises, especially combined with outstretched arms with even minimal loads, can increase the compressive forces on the spine.

I asked Mrs. S how tall she was and whether she had lost height recently. She said she had been taller when she was younger, but her height had not changed as of her physical examination a year ago. I asked if her posture had changed. She didn't think so, but she felt it was harder to straighten up, something she had worked on regularly over the years.

Patients with spinal stenosis often have trouble with activities that require prolonged standing or changes of position. These activities can over-extend the spine and increase compressive forces (as does walking). Mrs. S reported no such problems, but I suspected there had to be some issues. I asked if Mrs. S had changed the way she did her activities of daily living because of this new problem. Did she sit more often, lean on surfaces for support, or bend further forward in her posture. She said she was sitting and leaning more and felt it was harder to straighten her posture.

I thought it might be necessary to help change the way Mrs. S performed some of her activities based on what she told me and what I had observed, but hopefully not at the expense of maintaining good conditioning and participation. Increasing Mrs. S's awareness of her posture and body mechanics would be an important element of her PT program.

I felt sure we knew *what* was causing Mrs. S's symptoms. I wanted my physical exam to tell us *why* and hopefully give me some insight into opportunities for change. With spinal stenosis, we look for ways to lengthen, decompress, and decrease shearing forces at the spine in order to alleviate excessive compression during weight-bearing activities. I observed Mrs. S's standing posture and noted a significantly forward head position, increased thoracic kyphosis (humpback), protruding abdomen, increased curvature of the spine with significant density changes in the para-spin-

*continued on next page*

## Narrative (Jane Loureiro)

*continued from previous page*

al muscles. When Mrs. S sat, her thoracic kyphosis was unchanged, but her lumbar spine became more flexed. Her thoracic spine was fairly fixed and didn't change much when I applied corrective, distractive, or compressive force. But her lumbar spine moved more and compensated for the lack of thoracic spine mobility, especially in the sagittal plane resulting in more extension.

I screened for sensory and motor changes and balance and coordination problems. I asked Mrs. S to walk normally. I observed excessive lumbar extension, increased forward head posture and thoracic kyphosis, decreased thoracic spine mobility and minimal upper-body motion relative to the lower body. I asked Mrs. S to stand on one foot. I was surprised she was able to stand on one foot for several seconds without significant body sway. This is often difficult for people much younger. And though Mrs. S didn't maintain the stance for 30 seconds, (the target), I felt she did well for her age. However, to accomplish this, she extended her lumbar spine and leaned her upper body back. She couldn't adjust her posture in the single leg position on her own or with manual assistance and maintain her single-leg balance.

I observed symmetrical, decreased tone of her buttocks musculature, but not atrophy. I checked muscle strength and sensation, and reflexes in her lower extremities. There was some general hip weakness, primarily of the gluteus medius and maximus but no segmental weakness.

Patient-education and involving patients in their care is a cornerstone of our practice, and I often begin this process during my exam. It allows me to learn more about how patients function and how they learn. I described an exercise for Mrs. S's lower abdominals, pelvic floor, and postural extensor muscles while she was lying on her back. I asked her to contract the muscles as I demonstrated the technique. Mrs. S tended to flex more and bear down creating a valsalva pressure during this exercise. She had trouble keeping her hips and thoracic spine extended while contracting her abdominals.

Optimal function of these muscles is important for the improvement of postural stability and control and the prevention of further postural changes. There was some weakness of her trunk muscles particularly her lower abdominals, postural extensors, and scapulae retractors, but not inconsistent with Mrs. S's significant postural changes. Because of Mrs. S's history of urinary incontinence, I wanted to know more about the pelvic-floor muscles, as well. I asked Mrs. S to contract her pelvic-floor muscles only without bearing down or clenching her buttocks muscles, while I palpated for a discrete lower-abdominal muscle contraction. I would expect to feel this if the pelvic floor was contracting appropriately. To make sure she understood, I gently laid the back of Mrs. S's hand on my lower abdomen and performed the contraction for her. She tried again and the contraction was better but still weak. Because of the intimate relationship between the lower abdominal, hip, and pelvic-floor muscles, improving strength in these muscles could help with Mrs. S's incontinence as well as her postural stability and alignment.

I evaluated the active and passive range of motion of Mrs. S's spine and hips, checking it in various positions including standing, sitting, supine, side-lying, and prone. There were significant restrictions in all movements of the thoracic spine with limited upper-extremity elevation because of her increased and stiff thoracic kyphosis. When I asked Mrs. S to elevate her arms or move her thoracic spine to twist, tip, or back-bend, it resulted in increased lumbar extension. I palpated the lumbar spine as Mrs. S moved and determined the level of the vertebral segments I was palpating based on landmarks at the pelvis and ribs. I felt motion occurring at L3-4, L4-5d L5-S1. The motion seemed to fulcrum at L3-4, and this segment moved anteriorly making palpation of the spinous process difficult. I tried to cue Mrs. S, then manually guide, then manually stabilize the thoracic, lumbar spine, and pelvis during these motions. I could see and feel that the stiffness at the thoracic spine was driving the excessive translation and extension at the lumbar spine. Through palpation and testing, I knew the density changes and lack of flexibility of the lumbar para-spinal muscles and soft tissues were also a factor. I thought about how these movements would affect Mrs. S's spine as she did her upper-body workout at the gym, twisted for golfing, or used her arms over head to wash her hair or reach cabinets in the kitchen.

I noted that I could stabilize the pelvis and begin to mobilize the soft tissues and vertebral segments in the lumbar and lower thoracic spine while controlling active and assisted thoracic-spine rotation to the right and left. Again, I continued to integrate patient-education into the exam, teaching Mrs. S about her posture and mobility as I began treatment using manual soft-tissue and joint-mobilization techniques. She didn't immediately get it. She had relied on these compensatory motions for mobility to accomplish her activities, but these motions were likely contributing to the abnormal loading and degenerative changes in her spine. I sat in front of Mrs. S and demonstrated the compensatory motions. I explained in more detail about her posture, where her motion was coming from, where it should be coming from, and what she should feel if she were doing it correctly. I explained that she should stop if she felt herself lose her best posture or her compensatory motions.

Mrs. S began to understand. I treated her for a few minutes then retested. I observed more mobility in her thoracolumbar area and less compensation. I often test, treat, then re-test during examinations and treatment to help determine whether my decision-making and selection and application of techniques are sound and effective.

I still needed to know more about how her lower extremities were affecting her lower back. Because Mrs. S experienced her problem while walking, and because of my observations of her posture and alignment while standing and walking, I was sure I would find some contributory elements in her hips. I tested her hip mobility. There was some restriction in the anterior hip joint capsule and a shortening of her hip flexor muscles resulting in limited hip

*continued on next page*

## Narrative (Jane Loureiro)

*continued from previous page*

extension. While prone, without manual stabilization at the pelvis, testing this hip tightness resulted in increased lumbar extension, so this would affect Mrs. S's back while standing or walking.

Again, I palpated the lumbar spine and felt the lumbar spine extend, fulcruming this time at L5-S1, but also L3-4, and L4-5. With stabilization at the pelvis, I could mobilize the hip and begin stretching the hip flexors without extending the lumbar spine. Her end feels (the resistance perceived at the end of passive joint testing) yielded to the stretch. Great, I thought, another area we could treat to affect Mrs. S's problem.

Finally, as Mrs. S lay on her side, I checked the regional and segmental motion of the lumbar spine. This would help verify the involved segments, determine the position and degree of hypo-mobility, or hypermobility and determine whether Mrs. S would be a good candidate for more specific joint-mobilization techniques to further unload the spine.

Considering precautions and contraindications, and taking into account Mrs. S's age and osteoporosis, but balancing that with the knowledge that Mrs. S likely loaded her spine more significantly in her activities at the gym and while golfing, I decided to proceed. I carefully positioned Mrs. S to determine the effect of the position on the spine. Then I fine-tuned my positioning of the spine and applied mobilization forces to the vertebral segments most involved. I controlled the lumbar motion in all three planes—frontal, sagittal, and transverse—and determined I could control the compensatory motions while applying directional and distractive forces. The segments were restricted, but the end feels were yielding, and Mrs. S tolerated the preliminary treatment very well.

I determined that this would be another treatment option. I was finished except for one thing. I asked Mrs. S to stand, and I handed her a standard cane with the handle resting on the ground. I asked her to pretend the cane was her golf club and show me her swing. She did, and again, the twisting motion through the back-swing and follow-through created more extension and fulcruming at the lumbar spine.

I asked Mrs. S to have a seat so I could go over my findings and explain what they meant. I told her I thought we could help, and she looked relieved. I told her the presence of degenerative changes in an MRI don't always correlate with pain or functional problems. In Mrs. S's case, the fact that her pain and functional problems were relatively new meant there was a good chance we could effect a change. I explained that I thought her pain was caused by a combination of factors and pointed out where I thought we could make changes in her alignment, mobility, and strength in her trunk and hips. We would need to change the way she did some of her exercises so we could stretch and strengthen more specifically. I described how we would start, and I reviewed the exercises we had used as assessment tools in the evaluation for Mrs. S's home program. I showed her how to contract her lower abdominals and pelvic floor in standing and instructed her in a couple of decompression techniques to relieve her discomfort when she was walking. I explained that over the next few weeks we would combine joint- and soft-tissue mobilization techniques here in the clinic with education and a home-exercise program. I thought it might take four–six weeks for the tissues in the back and hips to stretch out, and at least that long for the muscles in her trunk and hips to get stronger. But I thought she might notice less pain walking longer distances fairly soon.

My experience combined with my findings that several areas were likely contributing to her problem made me fairly sure of this. I explained she'd need to continue her home program for a lot longer than our treatments would last in order to maintain the improvement I thought she would see. I explained that strengthening her trunk, hips, and pelvic-floor muscles could help reduce the risk of falls, a common problem as people age, and that these exercises might help with her urinary incontinence. Mrs. S was pleased to hear this. We discussed the exercises she was doing at the gym and how she was doing them, and agreed I would consult with her trainer to help her be more aware of Mrs. S's situation.

I counseled Mrs. S that she was ultimately the one who would need to understand and control the positions of loading on her spine at the gym and during other activities. Mrs. S felt she could do this. I told her we would practice better posture and body mechanics for bending, lifting, pushing, pulling, reaching, and carrying.

After our third visit, Mrs. S reported she had walked to and from her mail box without pain. By then, I had spoken to Mrs. S's trainer and Mrs. S planned to return to the gym the following week. We continued specific joint- and soft-tissue mobilization techniques to the spine and hips and Mrs. S performed her home program well. After about six weeks, she was working on her home program independently and had returned for a follow-up. She was back at the gym but hadn't played her usual nine holes of golf yet. She no longer had pain walking distances, and she was very pleased. We decided Mrs. S did not need further PT; she'd get back to golfing and continue her home program. If she did have any trouble, I asked her to call me. She assured me she would.

### Comments by Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse

If we didn't have an appreciation for the complexity and nuance of the practice of physical therapy before reading this narrative, we certainly do now. Jane allowed us a glimpse into her assessment, thought processes, and decision-making in her meticulous care of Mrs. S. Every movement Mrs. S made, the way she handled her gym bag, her walk, her activities of daily living, factored into Jane's plan of care.

This narrative is a study in the ability of a clinician to observe, process, fine-tune, adapt, and then start all over again to ensure every possible solution is being considered. It also speaks to the importance of open and honest, two-way communication between patient and caregiver. That kind of communication fosters trust and leads to optimal outcomes. Jane's caring manner and obvious skill evoked a strong sense of trust in Mrs. S.

Thank-you, Jane.

## Macaluso Award Ceremony

*continued from front cover*

2007, friends, family, and co-workers came together to celebrate the accomplishments of these four highly esteemed clinicians.

In her opening comments, senior vice president for Patient Care, Jeanette Ives Erickson, RN, invoked the memory of Stephanie Macaluso, RN, saying, "Her lessons live on in the clinical practice of today's recipients and in countless others who provide exemplary care to our patients and families every day."

Ives Erickson framed the event against the backdrop of David Dibble's book, *The New Agreement in Healthcare: Healing a System on Life Support*. In it, Dibble cites four principles he believes need to be embraced if the American healthcare system is to survive and flourish. The principles are: find your purpose; support and teach others; be a systems thinker; and practice a little every day.

Said Ives Erickson, "Today's Macaluso recipients embody these principles and more as they 'routinely' provide expert care in their respective areas of specialization."

Associate chief nurse, Dawn Tenney, RN, shared some observations on, "Excellence in Patient Care," citing the work of Tom Peters and Robert Waterman in their book, *In Search of Excellence*. In a study of some of Fortune 500's top-performing companies, Peters and Waterman found common themes that they attributed to the success of these large corporations. Some of those themes

*continued on next page*

Dawn Tenney, RN

Corrina Lee, RN

Jane Loureiro, PT

An interested spectator

Supporting their colleague, are physical therapists (l-r): Cheryl Brunelle, PT; Jean O'Toole, PT (former Macaluso Award recipient); Diane Plante, PT (former Macaluso Award recipient); Janet Callahan, PT; Ellen Tighe Ventola, PT; Marie Brownrigg, PT; and Jackie Mulgrew (former Macaluso Award recipient)

## Macaluso Award Ceremony

*continued from previous page*

include:

- a bias for action
- being close to the customer
- autonomy and entrepreneurship
- productivity through people
- value-driven management
- sticking to the knitting (staying with the business you know)
- running a 'lean' business

Said Tenney, "These are the same themes that drive patient care at MGH—clinician-patient relationships, clinical knowledge and decision-making, sound leadership, and teamwork. These are the same themes that emerged in the clinical narratives of each of our Macaluso recipients."

Ives Erickson read excerpts from letters of support as each recipient came forward to accept her award. In a letter written in support of Corrina Lee's nomination, Arlan Fuller, MD, chief of Gynecological Oncology, wrote, "Corrina provides the intellectual stimulation to develop high standards of nursing practice for her peers. She is a paradigm for our students and residents, helping new trainees adapt to practice on Bigelow 7. Most of all, it is her love of patients and her wonderful and supportive relationships with young and old alike that sets her apart and makes her so deserving of this award."

One letter of support for Jane Loureiro's nomination came from inpatient physical therapy clinical director, Nancy Goode, PT, who wrote, "I've worked closely with Jane on projects related to inpatient and outpatient PT services, the evaluation of the integrated electronic management systems, and IBM's Safe and Lean initiative. Jane is always prepared; she thoughtfully asks questions for information or clarification; she is open to input from others; and she always provides an objective perspective. Jane integrates the knowledge and skills she has developed into her own personal evolution to be the most effective clinical leader she can be."

About Paula Nelson, Lisa Leffert, MD, co-chief of Obstetrical Anesthesia, wrote, "When Paula takes care of patients, she is a superb advocate. On many occasions, she has integrated her clinical skills and insight into human nature to guide patients through difficult labors. She is equally skilled with the older, highly educated patients as she is with young teens. Although, exceedingly kind and compassionate, Paula knows how to set limits with patients when it's important for their safety and care. She has a gift for balancing time pressures with the imperative to deliver safe, high-quality care. Paula has the respect of all members of the multi-disciplinary team and is able to be extremely effective in leading the team."

In support of Angela Sorge's nomination, Siobhan Haldeman, RN, Ellison 11 clinical nurse specialist, wrote, "Angela has offered unit-based in-services for her peers to enhance their knowledge of clinical problems and patient-education principles. She maintains all the patient-education materials for the unit, which can be a daunting task for a unit on the cutting edge of procedures to treat vascular diseases. While completing an internship with the Blum Patient & Family Learning Center, Angela helped develop discharge guidelines for patients undergoing EP and pacemaker procedures. She coordinated and secured funding to have these materials translated into other languages and posted on the web."

Each recipient had an opportunity to say a few words, and each took the opportunity to acknowledge the support of their families, co-workers, and the entire healthcare team.

In closing, Ives Erickson thanked the members of the Macaluso Review Board whose difficult task it was to select the recipients from among numerous deserving nominees.

Said Ives Erickson, "Congratulations to Corrina, Jane, Paula, and Angela, and thank-you for the incredible work you do every day."

(L-r): Sorge, Lee, Nelson, and Loureiro

# Past and present Macaluso Award recipients

September 5, 1996, Stephanie Macaluso, RN

July 2, 1998
- May Cadigan, RN
- Pat English, RRT
- Valerie Fullum, LICSW
- Sarah Rozehnal Ward, CCC/SLP

December 17, 1998
- Maureen Beaulieu, RN
- Tessa Goldsmith, CCC/SLP
- Diana Grobman, RN
- Karen Lechner, LICSW
- Donna Slicis, RN

July 1, 1999
- Rochelle Butler, LPN
- Alice Chaput, RN
- Diane Plante, PT
- Louise Sethmann, RN

February 1, 2000
- Elizabeth Johnson, RN
- Sucheta Kamath, CCC/SLP
- Sandra McLaughlin, LICSW
- Fredda Zuckerman, LICSW

June 15, 2000
- Emilyn S. Bellavia, RN
- Mary Elizabeth McAuley, RN
- Diane McKenna-Yasek, RN
- Marica Wasenius Rie, PT

December 7, 2000
- Gae Burchill, OTR/L
- Pamela DiMack, RN
- Claire Farrell, RN
- Marie Elena Gioiella, LICSW
- Irene Giorgetti, RN
- Lisa Sohl, RN
- Susan Thel, MSW

June 21, 2001
- Neila Altobelli, RRT
- Constance Dahlin, RN
- Sylvia Gordon, LICSW
- Catherine O'Malley, RN

December 13, 2001
- Clare Beck, RN
- Anita Carew, RN
- Robert Goulet, RRT
- Kristen Jacobsen, SLP
- Thomas Lynch, RN

June 13, 2002
- Sharon Brackett, RN
- Marguerite Hamel Nardozzi, LICSW
- Mary Lou Kelleher, RN
- Judith Lynch, RN
- Kristin Parlman, PT
- Debra Smith, RN

December 12, 2002
- Kathryn Best, RN
- Jennifer Kelliher, RN
- Michael McElhinny, MDiv
- Carol McSheffrey, LICSW
- Jean O'Toole, PT

December 11, 2003
- Erica Edwards, RN
- Kimberly Stewart, CCC-SLP
- Cynthia Thibodeau, PT
- Mara Wernick Robinson, PT
- Brenda Whelan, RN

December 9, 2004
- Betty Ann Burns-Britton, RN
- Danielle Doucette, RRT
- Alison Squadrito, PT
- Mary Zwirner, LICSW

December 8, 2005
- Ann Eastman, RN
- Judy Foster, RN
- Jackie Mulgrew, PT
- Virginia Sigel, LICSW

January 11, 2006
- Corrina Lee, RN
- Jane Loureiro, PT
- Paula Nelson, RN
- Angela Sorge, RN

# Domestic violence education and support group

The Employee Assistance Program is offering a confidential, ten-week education and support group for women employees who have been affected by domestic violence. The group is free and confidential and open to all women employees of the Partners HealthCare System

The first meeting will be held Thursday, March 1, 2007, from 4:30–6:00pm
For information and location, contact Donna at 617-726-6976 or 866-724-4EAP

# Maintaining compassionate care

**February 8–9 2007**
**Sessions held at the MGH Institute for Health Professions in Charlestown**

Conference is sponsored by the MGH IHP Ethics Initiative, the PCS Institute for Patient Care, and the PCS Ethics in Clinical Practice Committee; supported by the Kenneth B. Schwartz Center

For information, e-mail epipes@partners.org, or erobinson1@partners.org



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Please recycle

# Expanding our medical interpreter access

To make medical interpreter services more accessible to all patients, MGH is expanding its telephone interpretation services by providing handset-free conference phones on patient care units.

*Question:* When will the service be available?

*Jeanette*: Roll-out of the new phones begins this month with every inpatient unit receiving special phones that can be brought to patients' rooms for medical interpreter services.

*Question:* Will the phone service replace in-person medical interpreters?

*Jeanette*: No. Telephone interpretation will supplement the services of medical interpreters, enabling them to provide more frequent and timely communication with patients. We've used telephone interpretation services in the past, but the addition of these new telephones on patient care units will give staff better access to the service.

*Question:* How will staff know how to use the phones?

*Jeanette*: Staff will be trained by Interpreter Services on how to use the phones and how to work effectively with a remote interpreter to achieve the best possible outcomes. And step-by-step instructions will be attached to every phone.

*Question:* How will it work?

*Jeanette*: Staff will bring the phone from its assigned place on the unit to the patient's room and connect it to an outlet and phone jack. Staff will call the interpreter-service provider. After the interpretation, when the phone is no longer needed, staff will disconnect the telephone, disinfectant it, and return it to its assigned spot. Then staff will document telephone interpreter services in the patient's record.

*Question:* How does the phone link to the medical interpreter?

*Jeanette*: Staff will call a five-digit MGH extension to link to an operator who'll ask which language is being requested (and some other information) before transferring the call to the appropriate interpreter.

*Question:* What languages are available by telephone?

*Jeanette*: Most languages are available, including languages for which we may not have an MGH interpreter on staff or on-call.

*Question:* Will this service be available nights and weekends?

*Jeanette*: Yes. Telephone interpreter services are available 24 hours a day, seven days a week.

*Question:* Does the unit or the patient pay for the service?

*Jeanette*: The call is toll-free. The service is paid for by Interpreter Services.

*Question:* If we think the situation warrants a medical interpreter in the room, can we still request that a medical interpreter be present?

*Jeanette*: Absolutely. A medical interpreter in the room with the patient and caregiver will be the first choice in many situations. When interpreters are not available in person, telephone interpretation is another option.

I'm sure staff will become increasingly comfortable reaching for the telephone to communicate with their patients throughout the day. Access to interpretation services by phone will enhance patient care and support staff in all their interactions with patients.

*Question:* How can we learn more about this service?

*Jeanette*: Interpreter Services is offering training sessions for employees in all departments. For more information about telephone interpretation services, e-mail: mghphone-interpreting @partners.org.

## MGH is committed to improving hand hygiene

### *Hand Hygiene Quiz*

1) What is the *best* way to prevent the spread of germs that cause infections?
   a) Make sure your vaccinations are up to date
   b) Block coughs and sneezes with a tissue or folded arm
   c) Use good hand hygiene

2) What is the fastest and most effective form of hand hygiene for healthcare workers?
   a) Wash hands with soap and water
   b) Use an alcohol-based hand rub

3) When should hands *always* be washed?
   a) When visibly soiled
   b) Before eating
   c) After using the bathroom
   d) All of the above

4) When should you perform hand hygiene?
   a) Before and after contact with patients
   b) Before and after contact with the patients' environment
   c) Before eating, and after using the bathroom
   d) All of the above

Stop the Transmission of Pathogens
Infection Control Unit
Clinics 131
726-2036

5) What special procedures may be recommended when caring for patients with an infection caused by a spore-forming organism such as *C.diff*?
   a) Wash hands with soap and water after contact
   b) Use Cal Stat after hand-washing
   c) Clean environmental surfaces frequently
   d) All of the above

Answers: 1) c; 2) b; 3) d; 4) d; 5) d

# Educational Offerings



| When | Description | Contact Hours |
|---|---|---|
| February 12 and 26<br>8:00am–3:00pm | **Advanced Cardiac Life Support (ACLS)—Provider Course**<br>Day 1: O'Keeffe Auditorium. Day 2: Thier Conference Room | - - - |
| February 14<br>8:00am–2:00pm | **New Graduate Nurse Development Seminar I**<br>Training Department, Charles River Plaza | TBA |
| February 14<br>8:00–11:30am | **Intermediate Arrhythmias**<br>Yawkey 10-660 | TBA |
| February 14<br>12:15–4:30pm | **Pacing Concepts**<br>Yawkey 10-660 | TBA |
| February 14<br>11:00am–12:00pm | **Nursing Grand Rounds**<br>Haber Conference Room | 1 |
| February 14<br>1:30–2:30pm | **OA/PCA/USA Connections**<br>"JCAHO: a debriefing." Bigelow 4 Amphitheater | - - - |
| February 15<br>8:00am–12:00pm | **CVVH Core Program**<br>Yawkey 2210 | - - - |
| February 22<br>1:30–2:30pm | **Nursing Grand Rounds**<br>"Do the 'Write' Thing: Simple Steps to Writing and Getting Published."<br>O'Keeffe Auditorium | 1 |
| February 23<br>8:00am–4:30pm | **Pediatric Advanced Life Support (PALS) Instructor Class**<br>Training Department, Charles River Plaza | - - - |
| February 28<br>8:00am–2:30pm | **New Graduate Nurse Development Seminar II**<br>Training Department, Charles River Plaza | TBA |
| March 2<br>8:00am–4:30pm | **Assessment and Management of Patients at Risk for Injury**<br>O'Keeffe Auditorium | TBA |
| March 7, 12, 14, 19, 21, and 26<br>7:30am–4:30pm | **Greater Boston ICU Consortium CORE Program**<br>Mount Auburn Hospital | TBA |
| March 7<br>8:00am–4:30pm | **Phase I Wound-Care Education Program**<br>Training Department, Charles River Plaza | TBA |
| March 9 and 26<br>8:00am–3:00pm | **Advanced Cardiac Life Support (ACLS)—Provider Course**<br>Day 1: O'Keeffe Auditorium. Day 2: Thier Conference Room | TBA |
| March 12<br>7:30–10:30am/12:00–3:00pm | **CPR—American Heart Association BLS Re-Certification**<br>FND 325 | - - - |
| March 13<br>8:00am–12:30pm | **BLS Certification for Healthcare Providers**<br>FND 325 | - - - |
| March 14<br>8:00am–4:30pm | **Phase I Wound-Care Education Program**<br>Training Department, Charles River Plaza | TBA |
| March 14<br>8:00am–2:00pm | **New Graduate Nurse Development Seminar I**<br>Training Department, Charles River Plaza | TBA |
| March 14<br>11:00am–12:00pm | **Nursing Grand Rounds**<br>O'Keeffe Auditorium | 1 |
| March 14<br>1:30–2:30pm | **OA/PCA/USA Connections**<br>"Understanding Diabetes." Bigelow 4 Amphitheater | - - - |
| March 14<br>4:00–5:00pm | **Nursing Research Committee Journal Club**<br>Yawkey 2210 | 1 |
| March 15 and 16<br>8:00am–4:30pm | **Pain Relief Champion Day**<br>Day 1: Yawkey 2210; Day 2: Yawkey 10-660 | TBA |

*For detailed information about educational offerings, visit our web calendar at http://pcs.mgh.harvard.edu. To register, call (617)726-3111.*
*For information about Risk Management Foundation programs, check the Internet at* http://www.hrm.harvard.edu.

# History and background of the Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award

In August of 1996, Jeanette Ives Erickson, RN, senior vice president for Patient Care, formally announced the creation of the Excellence in Clinical Practice Award (originally called the Expertise in Clinical Practice Award). The purpose of the award is to recognize direct-care providers whose practice exemplifies the expert application of values put forth in our vision: practice that is caring, innovative, guided by knowledge, built on a spirit of inquiry, and based on a foundation of leadership and entrepreneurial teamwork.

The first recipient of the award, in 1996, was Stephanie M. Macaluso, RN, thoracic clinical nurse specialist. In honor of the high standards she set as an expert caregiver, the award is now known as the Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award.

Macaluso embodied the qualities and characteristics of an expert practitioner. She was known for her strong knowledge base and intuitive skills. She knew when a clinical situation was changing even when common indicators remained unchanged. As an expert coach, she was one on whom peers relied and to whom physicians responded immediately because of her solid, proven track record of sound judgement.

Macaluso did not stand outside of a patient's realm of experience in her role as clinical teacher. She stood alongside patients conveying empathy and genuine concern. Macaluso's ability to be with patients in a way that acknowledged their shared humanity was the basis of her caring practice.

Macaluso understood the relationship of health, illness and disease. It was this understanding that led her in her caring work to seek patients' stories. She knew that every illness had a story—relationships were disturbed, plans were thwarted, and symptoms became laden with meaning as to what else was going on in a patient's life.

Macaluso had the uncanny ability to put herself in touch with others and bring the encounter to an intimate level. It's hard to express how she made this contact with patients; maybe it was the way she approached them, the questions she asked, or the language she used. But somehow, they trusted that she knew what she was talking about. This trust and understanding allowed her to connect with patients and promote a sense of caring.

Macaluso had a keen ability to nurture staff and enlist them in her love of patient care. She epitomized the essence of what nursing is truly about.

We continue to celebrate expert practice throughout Patient Care Services. The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award is now given annually. Registered nurses, occupational therapists, respiratory therapists, physical therapists, speech-language pathologists, social workers and chaplains who provide direct care are eligible for the award and may nominate co-workers whose practice exemplifies the standards described earlier.

Clinicians who are nominated submit a professional portfolio which is reviewed by a selection committee comprised of clinicians, administrators, and MGH volunteers. To assist recipients in achieving both personal and professional development, recipients receive tuition and travel expenses to the professional development conference of their choice.

The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award allows us to publicly re-commit ourselves to the highest standards of care we hold for our patients, and contribute to the on-going professional development of clinicians within Patient Care Services.

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